

Case Number:	CM15-0168760		
Date Assigned:	09/09/2015	Date of Injury:	10/10/2014
Decision Date:	10/08/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	08/27/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 43 year old male who sustained an industrial injury on 10-10-2014. Documents submitted for review list the date of injury as 09-22-2014. He reported right shoulder pain. On 02-10-2015, he underwent arthroscopic acromioplasty, arthroscopic Mumford, arthroscopic SLAP repair, arthroscopic debridement of partial rotator cuff tear and labral tear. According to a progress report dated 08-19-2015, the injured worker described an aching and stabbing sensation to the right shoulder girdle. There was no neck pain or radicular pain or numbness reported. Current pain was rated 4 on a scale of 1-10 with pain ranging between 2 to 8. Lidoderm gel was trialed with no benefit. Prior treatments before surgery included physical therapy and 3 injections. Since surgery he had been managed with Percocet, currently using 10-325 between 4 and 5 tablets a day. He had also completed additional physical therapy. The provider also noted in the progress report that the injured worker was currently managing symptoms with Percocet 10-325 mg using between 3 and 4 tablets daily. Examination of the shoulder demonstrated limited range of motion on abduction for the right shoulder to 100 degrees, forward flexion to 120 degrees and external rotation to 40 degrees. Rotator cuff strength was 5 out of 5 with negative empty can test. Hawkins Kennedy and speed's test was positive for pain to the shoulder. Urine drug screen on 04-16-2015 was positive for Oxycodone. This report was submitted for review. Electromyography was normal. Diagnoses included pain in joint shoulder, adhesive capsulitis shoulder, issue repeat prescriptions and chronic right shoulder pain status post SLAP repair, acromioplasty, Mumford procedure and debridement. Exam findings were consistent with adhesive capsulitis. Percocet reduced pain as low as a 1 with increased

tolerance for range of motion exercises. There were no adverse reactions reported to medications. Prior urine drug screen and CURES had been appropriate. Medications prescribed included Percocet 10-325 mg 2 scripts dated 08-21 and 09-20 and Ibuprofen 800 mg. He was to return in 6 weeks for a follow up. He was to follow up with another provider for a permanent and stationary appointment. Work status included restricted duty of repetitive tasks for 30 minutes at a time, no vibratory tools or guns, no overhead worker at or above 90 degrees, change positions as necessary, lifting and carrying 5-15 pounds, pushing and pulling light (10-25 pounds). Duration of restrictions included a start date of 08-24 x 6 weeks. On 08-24-2015, Utilization Review non-certified the request for Percocet 10/325 mg #120 mg for 30 day Supply with 1 refill noting that the submitted documentation did not provide specifics to indicate that utilization of a narcotic medication significantly enhanced functional capabilities.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Percocet 10/325mg #120mg for 30 Day Supply With 1 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dosing.

Decision rationale: The claimant sustained a work injury in October 2014 and underwent a labral repair with acromioplasty in February 2015. When seen, he had completed physical therapy treatments. Medications included Percocet being taken 3-4 times per day and referenced as decreasing pain from 2-8/10 to as low as 1/10 with increased tolerance for exercise. It had previously been taken up to five times per day. The claimant had tried topical lidocaine which had been ineffective. Physical examination findings included decreased right shoulder range of motion with positive impingement and Speed's testing. Diagnoses included adhesive capsulitis. Percocet was continued at a total MED (morphine equivalent dose) of 60 mg per day. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse or addiction and medications are providing decreased pain with improve tolerance for exercise. The total MED is less than 120 mg per day consistent with guideline recommendations. However, the claimant is taking this medication 3-4 times per day and prescribing a two month supply at 4 times per day was not appropriate. The request cannot be accepted as being medically necessary.